New Hampshire Medical Eligibility Determination (MED) Application

Directions for Completing the Application

All information on pages one and two, unless specified "office use only" will be completed by the individual making the referral.

Name: Print applicant's legal name clearly, using capital letters for Last, First and Middle Initial (MI).

MID: This refers to the individual's Medicaid Identification Number **(MID) that consists of 11 digits.**

Date: The date refers to the day the application was completed. Use two digits for the month and the day, and four digits for the year. (Example: 01/01/2006)

APPLICATION INFORMATION:

Referral Source: Please identify the category of referral.

Referral Agency/Organization: Enter the name of the agency or organization that is completing the request for assessment, for example, specific hospital, nursing facility, resource center, district office, etc.

Name of Person Completing the Request: Enter the name of person completing the application form.

Phone: Enter phone number of person completing the application form.

TRANSFER INFORMATION:

If this is a transfer from hospital to nursing facility, check "yes" in the appropriate box.
If this is a transfer from hospital to swing bed, check "yes" in the appropriate box.

Facility Requesting Transfer: Identify the hospital or nursing facility that the individual wishes to leave.

Contact Person: Identify the person who is responsible for making arrangements for the transfer and who can answer any questions about the process.

Phone: Enter the number and extension of the contact person listed.

Projected Transfer/Discharge Date: Enter known or expected date the individual will transfer from the current facility to a new facility. If a date of discharge changes from what was submitted on form, please notify the Bureau of Elderly and Adult Services (BEAS) at 603-271-4342 with the correct date. Correct dates are necessary to ensure correct billing.

Is This a Medicare Transfer? If Medicare is the **PRIMARY PAYER** source for the facility the person is being discharged from AND admitted to, please check "yes". If **MEDICAID** is the primary payer for the facility the person is being discharged from OR admitted to, check "no".

NOTE: Long Term Care medical approval from BEAS is not necessary when the primary payer is private insurance or Medicare.

DEMOGRAPHICS: IDENTIFICATION AND BACKGROUND INFORMATION

1. Social Security No.: Enter the applicant's nine-digit Social Security number.

2. Date of birth: Use two digits for the month and day, and four digits for the applicant's year of birth. For example, January 2, 1918 should be entered as 01-02-1918.

3. Gender: Check appropriate box for the applicant's gender - male or female.

4. Age: Enter applicant's current age.

5. MR/DD or Serious Mental Illness: Check the appropriate box to indicate whether or not the applicant has a developmental disability / mental retardation, or serious mental illness. If the application is a request for nursing facility approval, PASARR review is necessary for any individual with developmental disabilities, mental retardation or serious mental illness.

6. Mailing Address: Give applicant's **permanent** address and phone number. Note: There must be a street and a town listed in addition to a post office box. If individual is in the hospital, give applicant's address prior to admission. If individual is currently at a residential care or nursing facility, use the name and address of that facility only if placement is expected to be permanent.

7. Secondary Address: If individual has a legal representative who needs to receive information, be sure to include that address as the secondary address.

8. Marital Status: Choose the answer that best describes the individual's current marital status.

9. Primary Language: Check the appropriate box for the language the individual primarily speaks or understands. If the primary language is none of the languages listed, check the "Other" box and specify the primary language in the space provided.

10. Communications: Check the appropriate box if no assistance is necessary. If an interpreter (including sign language) or a type of assistive device for communication is necessary, check the appropriate box and specify the kind of interpreter/device required. Check "Other" if applicable and specify in space provided.

11. Usual Place of Residence: Individual completing the application will check one item in column A that best represents the individual's usual living situation. The nurse will identify where the person is located at the time of the assessment, and check that location in column B. Please use the following descriptions:

Own home – Lives in a house or apartment building with responsibilities for paying the bills/rent.

Another's Home – Lives in a house or apartment building with another individual who is primarily responsible for paying the bills/ rent, etc.

Adult Family Home – A specific program where an individual resides with a family in a home that has been approved by BEAS and the home is supervised by an HCBC-ECI designated agency (Adult Family Care/Kinship program).

Assisted Housing – Refers to the following facilities with bundled services:

- Whitaker Place, Concord
- Summercrest, Newport
- Meetinghouse, Manchester

Congregate Housing – Refers to the following facilities with bundled services:

- Sunrise Towers
- The Tavern

Homeless – Has no home or address.

Hospital – Currently an in-patient; should never be selected for usual place of residence unless residing at New Hampshire Hospital.

Hotel/Motel – Permanent address is a residence hotel or motel.

Nursing Facility – Permanent address is a nursing facility or nursing care center; individual no longer maintains another residence.

Residential Care – Permanent address is a facility that is licensed to provide room and board, personal care, homemaking, and supervision in return for a bundled-service payment. It may be referred to by the term supported residential care, assisted living, group home and other terms, but specifically excludes the facilities identified as assisted or congregate housing.

Other – Any other permanent living situation not described above, please describe.

12. Usual Living Arrangement: Check the box which accurately describe the individual's normal living circumstances. If the individual is being assessed for nursing facility eligibility while at the hospital, check appropriate box for his/her residence prior to hospitalization. Check "Other" and specify on line provided if needed.

13. Medicaid Status: A determination of where an individual is in the process of financial eligibility. Please check the appropriate box.

> **Application filed** – Check yes if financial information has been provided to DFA. Enter the date the application was made in the space provided. Check no if there is no financial information on file with DFA.
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> **Eligible -** Check yes if the individual is financially eligible for program being requested. Check no if the individual is not financially eligible for this program and financial eligibility is not anticipated in the immediate future.
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> **Eligibility pending** – Check yes if a financial application is in progress at the DFA and is awaiting a medical eligibility decision. Check no if a determination of financial eligibility has not been reached as of the assessment start date.

14. Physician - Primary/Specialist/Dentist/Eye Doctor: List name, address, phone number and date of last visit for each of the care providers listed.

15. Responsibility/Legal Guardian: Please identify who makes legal decisions for the individual based on the information listed below. The individual completing the form must see the legal documentation before checking any box other than "self" and send in that documentation with the application. In the case of a DPOA, it is necessary to know whether or not it has been activated by a physician, and must be accompanied by that information.

> **Durable Power of Attorney For Health Care -** An individual, the principal, gives another the authority to make any and all health care decisions (except as may be specifically stated otherwise) when the principal is no longer capable of making those decisions him/herself and becomes effective only when the principal becomes incapable of making decisions AS CERTIFIED IN WRITING BY THE PRINCIPAL'S ATTENDING PHYSICIAN AND FILED IN THE PRINCIPAL'S MEDICAL RECORD.
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> **Guardianship -** A guardian is a person appointed by the probate court to make health care, residential and other personal decisions for another person (called a ward) who is found by the court to be incapacitated. A guardian has a similar kind of authority as a parent has over a minor child. Under full guardianship, the ward loses the right to make his/her own decisions.
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> *Faced with a situation in which the person has a guardian, ask to see the court papers that describe the scope of the guardianship. The "Letters of Guardianship" should be reviewed. It should be made available by the guardian, but can also be*

obtained from the probate court. The guardianship order may or may not allow the guardian to make decisions about long term care and placement choices.

16. Advance Directives: Check all items that apply and have supporting documentation available. If there are no advanced directives or none are verified by documentation, check Unknown/Documentation unavailable.

Living Will - A document specifying the individual's preferences regarding measures used to prolong life when there is a terminal prognosis. It may specify that no heroic measures be used to prolong life when there is a terminal prognosis.

Do not resuscitate orders - In the event of respiratory or cardiac failure, the individual or family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore respiratory or circulatory function.

Do not hospitalize order - A document specifying that individual is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

Organ donation - Instructions indicating that the individual wishes to make organs available for transplantation upon death.

Autopsy request - Document indicating that the individual or family or legal guardian has requested that an autopsy be performed upon death. **[Note:** The family must still be contacted prior to performing the procedure.**]**

Unknown/Documentation unavailable - If none of above directives apply or cannot be verified by documentation in the medical records, check this box.

Other - Any other advance directive not described above, please describe.

17. Contacts: Emergency, Legal Guardian, other: List names, addresses, and phone numbers of those family members, friends or neighbors who act as the individual's support system, or who have a legal relationship with the individual. Please specify the contact individual's relationship to the person applying for services.

Approval of application submission: Obtain the signature of the individual or his/her legal representative if the individual understands and consents to the following::

The individual is agreeing to apply for a Medicaid program – Choices for Independence (CFI) or Nursing facility.

The individual must become Medicaid eligible (financial eligibility) in order to receive services from the Choices for Independence program or Nursing Facility services.

The individual is willing to participate in a Medical eligibility Determination assessment, which is an interview conducted by a Registered Nurse in the setting where the individual currently resides.

The individual signs the form indicating understanding of the application process and his/her desire to participate in the program.

Applicant Signature: Please have applicant or his/her legal representative sign and date the application prior to submission at ServiceLink Resource Center. Both pages of the application must be submitted by fax or US mail to the appropriate ServiceLink.

ServiceLink/Long Term Support Counselor:

On page one, "for office use only" please enter your name, ServiceLink site and the District Office working with the individual.

On page two, "for office use only", if information for application is obtained via telephone, page 2 will be mailed to the individual or his/her representative for a signature/consent to be obtained before the application will be accepted.

State Nurse:

On page one, "for office use only" , please check whether this is a new applicant or a redetermination visit for CFI, and enter your name and phone number.

Question 11. During assessment, check the usual residence of the individual and their current location during the assessment.